PATIENT CONSENT

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it's appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please contact us at info@aheadofbeauty.org

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient/Customer's Name (print): ____

Patient/Customer Signature: ____

Date: _________________________________

Please submit all signed forms to Submittals@aheadofbeauty.org
Subject: Consent Forms For: [Patient's Name]

RELEASE OF INFORMATION

I, the undersigned, do hereby approve Ahead of Beauty to release to insurance companies and doctor's offices the information required to receive authorization to assure payment of any portion of the bill incurred by myself that they are entitled to receive. That information being: my name, address, date of birth, the name of the doctor authorizing prescriptions, my client number, and the code numbers of the products required.

Patient/Customer's Name (print): ____

Patient/Customer Signature: ____

Date: _______________________________

FAX AND MESSAGE AUTHORIZATION

Dear Patient/Customer,

In accordance with new privacy laws dictated by HIPAA, we can no longer fax medical information or leave messages on your phone or with another person without your written consent. **PLEASE INITIAL AND SIGN BELOW.**

___________ I give my permission for the staff of Ahead of Beauty to fax medical information relating to services provided.

OR

___________ I DO NOT give my permission for the staff of Ahead of Beauty to fax medical information relating to services provided.

___________ I give my permission for the staff of Ahead of Beauty to call and/or leave a message at the following phone number_________________ concerning the receipt of shipments of products and /or relating to services provided.

OR

___________ I DO NOT give my permission for the staff of Ahead of Beauty to call and/or leave a message concerning the receipt of shipments of products and/or relating to services provided.

Patient/Customer's Name (print): ____

Date of Birth: _________________________________

Patient/Customer Signature: ____

Date: _________________________________

Please submit all signed forms to Submittals@aheadofbeauty.org
Subject: Consent Forms For: [Patient's Name]

HIPAA & MEDIA RELEASE AUTHORIZATION

I hereby authorize Ahead of Beauty and its duly authorized employees or agents, to publish the following personal health information or story that contains my name or likeness.

This photo or story may contain information relating to the diagnosis, treatment, and health care services provided or to be provided to me and/or my spouse and child by Ahead of Beauty and identifies my name and/or my spouse and child's name and other personally identifiable information. This information may be used in print media, on the radio, podcasts, TV, the Ahead of Beauty website, blog, and on the following social media platforms: Facebook, Twitter, Instagram, TikTok and YouTube.

I understand that any personal health information or other information released via the social media platform(s) above may be subject to redisclosure by such social media platform(s) and may no longer be protected by applicable Federal and State privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to SOWC. However, this authorization may not be revoked if Ahead of Beauty, its employee's, or agents have acted on this authorization prior to receiving my written notice.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to seek treatment with Ahead of Beauty, eligibility for benefits or enrollment or payment for or coverage of services.

Lastly, I understand I will not be compensated for the use of any images or my likeness that is used in any social media platforms. I also understand that Ahead of Beauty and it' s duly authorized employees or agents are not liable to notify photographers/agencies of the use of these photos, and it is between myself and the photographer to discuss the distribution rights of any images.

I agree and give my permission to the above stated information.

Patient/Customer's Name (print): ____

Patient/Customer Signature: ____

Date: _________________________________

Please submit all signed forms to Submittals@aheadofbeauty.org
Subject: Consent Forms For: [Patient's Name]

MODELING/APPERANCE RELEASE

For and in consideration of my engagement as a model for Ahead of Beauty, I hereby give my full permission to Ahead of Beauty, its agents, successors, assigns, clients, recipients of its services and products, to use my name, image and voice in conjunction with the production, marketing, publicizing, promotion and sale in any medium; including electronic, print, and live communications of the program, project or organization publications.

Signature: ____

***Permission for any/all Social Media and / or Publications. (Ex: Twitter, Facebook, Blogs, Website) ***

I hereby waive any right to inspect or approve the finished photograph, video, advertising copy or printed matter that may be used in conjunction therewith or the eventual use that it might be applied. I hereby release, discharge and agree to save harmless the photographer, his representatives, assigns, employees or any person or persons, corporation or corporations, acting under his permission or authority, or any person or persons, corporation or corporations, for whom he might be acting, including any firm publishing and/or distributing the finished product, in whole or in part, from and against any liability as a result of distortion, blurring alterations, optical illusion, or use in composite form, either intentionally or otherwise, that may occur or be produced in taking, processing or reproduction of the finished product, its publication or distribution of the same, even should the same subject me to ridicule, scandal, reproach, scorn or indignity.

I hereby warrant that I am over eighteen years of age and competent to contract in my own name as the above is concerned and/or have parental consent as signed below. This consent shall be a continuing consent for this and related programs or projects that may evolve from it without any limitations or reservations whatsoever other than those so stated in this release.

Model Name (print): __________________________________ Date of Birth: ________

Model Signature: ____

Parent Name (if applicable): ____

Parent Signature: ____

Date: ________________________________

Please submit all signed forms to Submittals@aheadofbeauty.org
Subject: Consent Forms For: [Patient's Name]